HEALTH BENEFIT COMPARISON

Effective January 1, 2008

THIS COMPARISON IS ONLY A SUMMARY OF BENEFITS. BENEFITS WILL BE ADMINISTERED AS DESCRIBED IN EACH PLAN'S SUBSCRIBER AGREEMENT OR PLAN DOCUMENT. FOR FURTHER DETAIL, REFER TO THOSE DOCUMENTS OR CALL THE INSURANCE CARRIER OR MCO. (HEALTH PLAN OPTIONS DIFFER BY BARGAINING UNIT/STATUS)

Plan Provisions	Wellmark BC/BS Deductible 3 Plus	Wellmark BC/BS Program 3 Plus	Wellmark BC/BS Iowa Select	Wellmark BC/BS Iowa Select	Managed Care Plans
			In Network (Select Provider)	Out-of-Network (Non-Select Provider)	Blue Access Blue Advantage UHC Choice HMO UHC Heritage Select
Deductible Single/Family	$300/$400 applies to all services. Any portion of deductible satisfied in last three months of year will be credited for following year as well.	$300/$400, inpatient services only.	$250/$500. Applies to both inpatient and outpatient services. Waived for services provided in office/clinic setting of Select Provider.	$250/$500. Applies to both inpatient and outpatient services.	None.
Coinsurance Percentage	20%. All services	20%. All services	10%	20%	Varies; see below.
Out-of-Pocket Limit Single/Family	$600/$800. All deductibles, coinsurance, and copayments go toward Out-of-Pocket Limit.	$600/$800. All deductibles, coinsurance, and copayments, except $15 office visit copayment, go toward Out-of-Pocket Limit. Separate $250/$500 Out-of-Pocket Limit for prescription drugs. Does not apply to medical Out-of-Pocket Limit.	$600/$800. Applies to services provided both in- and out-of-network. All deductibles, coinsurance, and copayments, except $15 office visit copayment, go toward Out-of-Pocket Limit. Emergency Room Copayment continues to apply after Out-of-Pocket Limit is met. Separate $250/$500 Out-of-Pocket Limit for prescription drugs. Does not apply to medical Out-of-Pocket Limit.	$600/$800. Applies to services provided both in- and out-of-network. All deductibles, coinsurance, and copayments, except $15 office visit copayment, go toward Out-of-Pocket Limit. Emergency Room Copayment continues to apply after Out-of-Pocket Limit is met. Separate $250/$500 Out-of-Pocket Limit for prescription drugs. Does not apply to medical Out-of-Pocket Limit.	$750/$1500. All copayments go toward Out-of-Pocket Limit with the exception of prescription drug copayments.
Benefits Available from Non-Participating Providers	Normal Plan benefits.	Normal Plan benefits.	Normal Plan benefits for Select providers.	Normal Plan benefits for non-Select providers.	None, unless prescribed, referred and approved by a Participating Physician, or in an Emergency Medical Condition, or with prior authorization from the Plan (when required).
Large Case Management	Alternative care set up on a case by case basis by Plan.	Alternative care set up on a case by case basis by Plan.	Alternative care set up on a case by case basis by Plan.	Alternative care set up on a case by case basis by Plan.	Alternative care set up on a case-by-case basis.
Lifetime Benefit Maximum	None.	None.	None.	None.	None.
Outpatient Surgery Setting	Required for certain procedures. Paid according to normal plan benefits when procedure done on an outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	Required for certain procedures. Paid according to normal plan benefits when procedure done on an outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	Required for certain procedures. Select provider obtains approval.	Required for certain procedures. Paid according to normal plan benefits when procedure done on an outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	Participating Physician will determine appropriate surgical setting.
Preapproval of Inpatient Admissions	Required.	Required.	Required.	Required.	Required.

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New Employee Preexisting Condition Waiting Period	11 months.	11 months.	11 months.	11 months.	None.
Second Surgical Opinion	Voluntary. Paid according to normal Plan benefits.	Voluntary. Paid according to normal Plan benefits.	Voluntary. Paid according to normal Plan benefits.	Voluntary. Paid according to normal Plan benefits.	Voluntary. Paid according to normal Plan benefits when received from Plan provider.
PHYSICIAN SERVICES					
Office Calls	20%, after deductible.	$15 copayment once per date of service **for exam only**; no coinsurance, no deductible. **Copayment does not apply to Out-of-Pocket Limit.** 20% coinsurance, no deductible for other office services.	$15 copayment once per date of service **for exam only**; no coinsurance, no deductible. **Copayment does not apply to Out-of-Pocket Limit.** 10% coinsurance, deductible waived in office setting for other office services.	$15 copayment once per date of service **for exam only**; no coinsurance, no deductible**.** **Copayment does not apply to Out-of-Pocket Limit.** 20% coinsurance, after deductible, for other office services.	$10.00 copayment per visit.
Routine Physicals	20%, after deductible, excluding travel, employment or athletic related/required. Limited to one physical per member per year.	20%, no deductible, excluding travel, employment or athletic related/required. Limited to one physical per member per year.	10%, deductible waived in office setting, excluding travel, employment or athletic related/required. Limited to one physical per member per year.	20% after deductible, excluding travel, employment or athletic related/required. Limited to one physical per member per year.	$10.00 copayment per visit, excluding travel, employment, or athletic related/required.
Maternity	20%, after deductible.	20%, no deductible for pre- and post-natal office visits.	10%, deductible waived in office setting for pre- and post-natal visits.	20% after deductible.	0% for delivery. $10.00 copayment for initial visit; remaining pre- and post-natal visits paid in full.
Routine Eye Exam	Not covered.	Not covered.	10%, deductible waived. Limited to one exam per member per year.	20%, deductible waived. Limited to one exam per member per year.	$10.00 copayment per visit. Limit of one exam per member per year.
Routine Hearing Exam	Not covered.	Not covered.	10%, deductible waived. Limited to one exam per member per year.	20%, deductible waived. Limited to one exam per member per year.	$10.00 copayment per visit. Limit of one exam per member per year.
Well Child Care	20%, to 7 years. No deductible.	20%, to 7 years. No deductible.	10% to 7 years. Deductible waived in office setting.	20%, to 7 years. No deductible.	$10.00 copayment per visit.
HOSPITAL SERVICES					
Room & Board	20%, after deductible. No limit on medical surgical days. Pre-certification of admission required by member.	20% after inpatient services deductible. No limit on medical surgical days. Pre-certification of admission required by member.	10%, after deductible. No limit on medical surgical days. Pre-certification of admission required by Select provider.	20%, after deductible. No limit on medical surgical days. Pre-certification of admission required by member.	0% if authorized. Semi-private basis, unless Medically Necessary to use a private room. May require prior approval.
Physician Services	20%, after deductible.	20%, after deductible.	10%, after deductible.	20%, after deductible.	0% if authorized.
Inpatient Surgery	20%, after deductible. Must be approved as inpatient procedure.	20%, after deductible. Must be approved as inpatient procedure.	10%, after deductible. Must be approved as inpatient procedure.	20%, after deductible. Must be approved as inpatient procedure.	0% if authorized.
Outpatient Surgery	0%, after deductible. Required for certain procedures.	0%, no deductible. Required for certain procedures.	10%, after deductible. Required for certain procedures. Approval obtained by Select provider.	20%, after deductible. Required for certain procedures.	0% if authorized.
Inpatient Supplies, Drugs, Medicines, etc.	20%, after deductible.	20%, after deductible.	10%, after deductible.	20%, after deductible.	0% if authorized.

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Inpatient Tests, ICU, Operating Room, Specialized Care, etc.	20%, after deductible.	20%, after deductible.	10%, after deductible.	20%, after deductible.	0% if authorized.
PRESCRIPTION DRUGS					
Prescription Drugs	20%, after deductible. 30-day supply	$5.00 preferred generic. $15.00 preferred brand. $30.00 non-preferred brand and non-preferred generic. 30-day supply. $250/$500 Out-of-Pocket Limit (This limit is separate from the Medical Out-of-Pocket Limit).	$5.00 preferred generic. $15.00 preferred brand. $30.00 non-preferred brand and non-preferred generic. 30-day supply. $250/$500 Out-of-Pocket Limit (This limit is separate from the Medical Out-of-Pocket Limit).	$5.00 preferred generic. $15.00 preferred brand. $30.00 non-preferred brand and non-preferred generic. 30-day supply. $250/$500 Out-of-Pocket Limit (This limit is separate from the Medical Out-of-Pocket Limit).	$5.00 generic. $15.00 preferred brand. $30.00 or 25% non-preferred brand, and non-preferred generic whichever is greater. 30-day supply. Rx must be for a covered service and from a plan pharmacy. No ancillary charges may be assessed. Copayments do NOT apply to Out-of-Pocket Limit.
Mail Order Prescription Drugs	Not Covered	$10.00 generic. $30.00 preferred brand. $60.00 non-preferred brand and non-preferred generic. 90-day supply $250/$500 Out-of-Pocket Limit (This limit is separate from the Medical Out-of-Pocket Limit).	$10.00 generic. $30.00 preferred brand. $60.00 non-preferred brand and non-preferred generic. 90-day supply $250/$500 Out-of-Pocket Limit (This limit is separate from the Medical Out-of-Pocket Limit).	No Coverage.	$10.00 generic, $30.00 preferred brand $60.00 non-preferred brand and non-preferred generic. 90-day supply Rx must be for a covered service and from a plan pharmacy. No ancillary charges may be assessed. Copayments do NOT apply to Out-of-Pocket Limit.
Prescription Oral Contraceptives and Contraceptive Devices	Covered	Covered.	Covered.	Covered.	Covered.
MENTAL/NERVOUS					
Inpatient Hospital Room & Board	20%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	10%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year	0%. Maximum of 30 days per member per calendar year.
Inpatient Physician Care	20%, after deductible Maximum of 60 days per member per calendar year.	20%. Maximum of 60 days per member per calendar year.	10%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	0%. Maximum of 30 days per member per calendar year.
Outpatient	20%, after deductible.	20%.	10%, deductible waived in office setting	20%, after deductible.	$10.00 copayment per visit. Maximum of 52 visits per member per calendar year.
SUBSTANCE ABUSE					
Inpatient Hospital Room & Board	20%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	10%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	20%. Maximum of 30 days per member per calendar year.

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Inpatient Physician Care	20%, after deductible Maximum of 60 days per member per calendar year.	20%. Maximum of 60 days per member per calendar year.	10%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	0%. Maximum of 30 days per member per calendar year.
Outpatient	20%, after deductible.	20%.	10%, deductible waived in office setting.	20%, after deductible.	$20.00 copayment per visit. Maximum of 30 visits per member per calendar year.
MISCELLANEOUS SERVICES					
Accidents	0%, after deductible for all treatment within 72 hours of accident.	0%, no deductible for all treatment within 72 hours of accident.	10%, deductible waived in office setting.	20%, after deductible. Emergency care covered at In-Network level.	$10 copayment office visit. $50 copayment for ER, waived if admitted. .
Allergy Treatment	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	$10.00 copayment per visit.
Ambulance	20%, after deductible.	20%, no deductible.	20%, after deductible.	20%, after deductible.	0% if Medically Necessary /Emergency Medical Services.
Blood, Blood Plasma, Blood Serum	20%, after deductible.	20%, no deductible.	10%, after deductible.	20%, after deductible.	0% if authorized.
Chiropractor	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	$10.00 copay if approved provider.
Dental Accident Care	0%, after deductible for services provided within 72 hours of accident. 20% thereafter for a maximum of 6 months from injury.	0%, no deductible for services provided within 72 hours of accident. 20% thereafter for a maximum of 6 months from injury.	10%, deductible waived in office setting. Limited to services provided within 72 hours of accident.	20%, after deductible. Limited to services provided within 72 hours of accident.	20% if authorized by the Company for injury to sound natural teeth. Services must be within 6 months of injury and injury must have occurred while member enrolled in plan.
Durable Medical Equipment	20%, after deductible.	20%, no deductible.	10%, after deductible.	20%, after deductible.	20% if prescribed by a Participating Provider and obtained from a supplier authorized by the Company.
Emergency Room (ER Care)	0%, after deductible. Also see section on “Accidents”.	0%, no deductible. Also see section on “Accidents”.	$50.00 copayment; waived if admitted. Copayment and coinsurance apply. Copayment applies after Out-of-Pocket Limit is met.	$50.00 copayment; waived if admitted. Copayment and coinsurance apply. Copayment applies after Out-of-Pocket Limit is met.	$50.00 copayment; waived if admitted.
Eyeglasses	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
Hearing Aids	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
Hemodialysis	20%, after deductible.	20%, no deductible.	10%, after deductible.	20%, after deductible.	0% if obtained in a center authorized by the Company.
Home Health Care	20%, after deductible. Pre-certification required.	20%, no deductible. Pre-certification required.	10%, after deductible. Pre-certification required.	20%, after deductible. Pre-certification required.	0% if authorized by the Company.
Hospice Care	20%, after deductible. Pre-certification required.	20%, no deductible. Pre-certification required.	10%, after deductible. Pre-certification required.	20%, after deductible Pre-certification required.	0% if Medically authorized by the Company.
Infertility Services	$25,000 per couple for covered services and supplies related to infertility treatment per lifetime.	$25,000 per couple for covered services and supplies related to infertility treatment per lifetime.	$15,000 per person for covered services and supplies related to infertility treatment per lifetime.		Not Covered
Nursing Facility Providing Skilled Care	20%, after deductible, unlimited days. Pre-certification required.	20% after deductible. Unlimited days. Pre-certification required.	10% after deductible. Unlimited days. Pre-certification required.	20% after deductible. Unlimited days. Pre-certification	0%. Maximum of 120 days per member per calendar year.

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Occupational Therapy	20%, after deductible. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	10%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	$10.00 copayment per visit. Maximum 60 visits per member per year.
Organ Transplants	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.	Heart, heart/lung, lung (single and double), liver, pancreas, kidney/pancreas, kidney, cornea, small intestine, autologous bone marrow, and allogeneic bone marrow transplants 100% covered if authorized by the Company. No coverage if experimental or in a nonauthorized Facility.
Outpatient Chemotherapy	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	$10 copayment per visit.
Physical Therapy	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	$10.00 copayment per visit. Maximum 60 visits per member per year.
Prosthetic Appliances and Other Devices	20%, after deductible.	20%, no deductible.	10%, after deductible.	20%, after deductible.	20% if authorized by Participating physician and obtained from an authorized supplier.
Respiratory Therapy	20%, after deductible payable, inpatient or outpatient. Must be hospital-based billed or as a part of approved home health services.	20%. Payable, inpatient or outpatient. Must be hospital-based billed or as a part of approved home health services.	10%, after deductible. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Must be hospital-based billed or as a part of approved home health services.	$10.00 copayment per visit. Maximum 60 visits per member per year.
Speech Therapy	20%, after deductible payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%. Payable, inpatient or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	10%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	$10.00 copayment per visit. Maximum 60 visits per member per year.
TMJ	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	Not covered.
X-Ray and Lab	20%, after deductible.	20%, no deductible.	10%, deductible waived in office setting.	20% after deductible.	0%
Dependent Child Age Limit	Age 19 or unlimited if a full-time student and unmarried.	Age 19 or unlimited if a full-time student and unmarried.	Age 19 or unlimited if a full-time student and unmarried.	Age 19 or unlimited if a full-time student and unmarried.	Age 19 or unlimited if a full-time student and unmarried.

Notice for members of plans underwritten by Wellmark Blue Cross and Blue Shield of Iowa (BCBS): Your plan's coverage percentage for hospital and other facility services does not reflect the actual payment to the provider. The actual payment to the provider is based on BCBS's contract with the provider. The percentage is used in this document for comparison purposes only. On any given claim, the amount represented by the coverage percentage times the covered charge may be satisfied by BCBS's payment to the provider plus any amounts the provider agrees to waive under its contract with BCBS. Please see your benefits booklet for more information.